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II

106TH CONGRESS
1ST SESSION

S. 1618

To promote primary and secondary health promotion and disease prevention services and activities among the elderly, to amend title XVIII of the Social Security Act to add preventive benefits, and for other purposes.

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 22, 1999

Mr. GRAHAM (for himself, Mr. JEFFORDS, Mr. CHAFEE, Mr. BRYAN, Mr. ROCKEFELLER, and Mr. KERRY) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To promote primary and secondary health promotion and disease prevention services and activities among the elderly, to amend title XVIII of the Social Security Act to add preventive benefits, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Medicare Wellness Act of 1999”.

6 (b) TABLE OF CONTENTS.—The table of contents is
7 as follows:

Sec. 1. Short title; table of contents.

- Sec. 2. Finding.
- Sec. 3. Definitions.

TITLE I—HEALTHY SENIORS PROMOTION PROGRAM

- Sec. 101. Healthy Seniors Promotion Program.
- Sec. 102. Sense of Congress regarding the response of HCFA to preventive health issues.
- Sec. 103. Sense of Congress regarding the efforts of HCFA to study health promotion and disease prevention for medicare beneficiaries.
- Sec. 104. Sense of Congress regarding the establishment of a medicare health promotion and disease prevention clearinghouse.

TITLE II—MEDICARE COVERAGE OF PREVENTIVE SERVICES

- Sec. 201. Counseling for cessation of tobacco use.
- Sec. 202. Screening for hypertension.
- Sec. 203. Counseling for hormone replacement therapy.
- Sec. 204. Screening for glaucoma.
- Sec. 205. Screening for diminished visual acuity.
- Sec. 206. Screening for hearing impairment.
- Sec. 207. Screening and counseling for osteoporosis.
- Sec. 208. Screening for cholesterol.
- Sec. 209. Elimination of cost sharing for current preventive benefits.
- Sec. 210. National falls prevention education and awareness campaign.
- Sec. 211. Program integrity.

TITLE III—MEDICARE HEALTH EDUCATION AND RISK APPRAISAL PROGRAM

- Sec. 301. Medicare Health Education and Risk Appraisal Program.

TITLE IV—DISEASE SELF-MANAGEMENT DEMONSTRATION PROJECTS

- Sec. 401. Disease self-management demonstration projects.

TITLE V—STUDIES AND REPORTS ADVANCING ORIGINAL RESEARCH IN THE FIELD OF DISEASE PREVENTION AND THE ELDERLY

- Sec. 501. MedPAC biannual report.
- Sec. 502. National Institute on Aging study and report.
- Sec. 503. Institute of Medicine 5-year medicare prevention benefit study and report.
- Sec. 504. Fast-track consideration of prevention benefit legislation.

1 **SEC. 2. FINDING.**

2 Congress finds that despite significant advancements
 3 in general research for health promotion and disease pre-
 4 vention among the elderly, there has been a failure in
 5 translating that research into practical intervention.

1 **SEC. 3. DEFINITIONS.**

2 As used in this Act:

3 (1) **COST-EFFECTIVE BENEFIT.**—The term
4 “cost-effective benefit” means a benefit or technique
5 that has—

6 (A) been subject to peer review;

7 (B) been described in scientific journals;

8 and

9 (C) demonstrated value as measured by
10 unit costs relative to health outcomes achieved.

11 (2) **COST-SAVING BENEFIT.**—The term “cost-
12 saving benefit” means a benefit or technique that
13 has—

14 (A) been subject to peer review;

15 (B) been described in scientific journals;

16 and

17 (C) caused a net reduction in health care
18 costs for medicare beneficiaries.

19 (3) **MEDICALLY EFFECTIVE.**—The term “medi-
20 cally effective” means, with respect to a benefit or
21 technique, that the benefit or technique has been—

22 (A) subject to peer review;

23 (B) described in scientific journals; and

24 (C) determined to achieve an intended goal
25 under normal, programmatic conditions.

1 (4) MEDICAL EFFICACY; MEDICALLY EFFICA-
 2 CIOUS.—The terms “medical efficacy” and “medi-
 3 cally efficacious” mean, with respect to a benefit or
 4 technique, that the benefit or technique has been—

5 (A) subject to peer review;

6 (B) described in scientific journals; and

7 (C) determined to achieve an intended goal
 8 under controlled conditions.

9 (5) MEDICARE BENEFICIARY.—The term
 10 “medicare beneficiary” means any individual who is
 11 entitled to benefits under part A or enrolled under
 12 part B of the medicare program, including any indi-
 13 vidual enrolled in a Medicare+Choice plan offered
 14 by a Medicare+Choice organization under part C of
 15 such program.

16 (6) MEDICARE PROGRAM.—The term “medicare
 17 program” means the health care program under title
 18 XVIII of the Social Security Act (42 U.S.C. 1395 et
 19 seq.).

20 (7) SECRETARY.—The term “Secretary” means
 21 the Secretary of Health and Human Services.

22 **TITLE I—HEALTHY SENIORS** 23 **PROMOTION PROGRAM**

24 **SEC. 101. HEALTHY SENIORS PROMOTION PROGRAM.**

25 (a) DEFINITIONS.—As used in this section:

1 (1) ELIGIBLE ENTITY.—The term “eligible enti-
2 ty” means an entity that the Working Group deter-
3 mines has demonstrated expertise in research re-
4 garding health promotion and disease prevention
5 among the elderly.

6 (2) WORKING GROUP.—The term “Working
7 Group” means the Healthy Seniors Working Group
8 established under subsection (d).

9 (b) PROGRAM AUTHORIZED.—The Secretary, subject
10 to the general policies and criteria established by the
11 Working Group and in accordance with the provisions of
12 this Act, is authorized to make grants to eligible entities
13 to pay for the costs of the activities described in subsection
14 (c).

15 (c) USE OF FUNDS.—An eligible entity may use pay-
16 ments received under this section in any fiscal year to
17 study—

18 (1) whether using different types of providers of
19 care who are not physicians and alternative settings
20 (including community-based senior centers) for the
21 implementation of a successful health promotion and
22 disease prevention strategy, including the implica-
23 tions regarding the payment of such providers, is
24 medically efficacious or medically effective;

1 (2) the most medically effective means of edu-
2 cating medicare beneficiaries and providers of serv-
3 ices regarding the importance of health promotion
4 and disease prevention among the elderly and identi-
5 fication of incentives that would increase the use of
6 new and existing preventive services and healthy be-
7 haviors by medicare beneficiaries; and

8 (3) other topics designated by the Secretary.

9 (d) HEALTHY SENIORS WORKING GROUP.—

10 (1) ESTABLISHMENT.—There is established
11 within the Department of Health and Human Serv-
12 ices a Healthy Seniors Working Group.

13 (2) COMPOSITION.—Subject to paragraph (3),
14 the Working Group established pursuant to sub-
15 section (b) shall be composed of 5 members as fol-
16 lows:

17 (A) The Administrator of the Health Care
18 Financing Administration.

19 (B) The Director of the Centers for Dis-
20 ease Control and Prevention.

21 (C) The Administrator of the Agency for
22 Health Care Policy and Research.

23 (D) The Assistant Secretary for Aging.

24 (E) The Director of the National Institute
25 on Aging.

1 (3) ALTERNATIVE MEMBERSHIP.—

2 (A) APPOINTMENT.—Any member of the
3 Working Group described in a subparagraph of
4 paragraph (2) may appoint an individual who is
5 an officer or employee of the Federal Govern-
6 ment to serve as a member of the Working
7 Group instead of the member described in such
8 subparagraph.

9 (B) DEADLINE.—If a member described in
10 subparagraph (A) elects to appoint an indi-
11 vidual under such subparagraph, such indi-
12 vidual shall be appointed not later than Decem-
13 ber 31, 2000.

14 (4) GENERAL POLICIES AND CRITERIA.—The
15 Working Group shall establish general policies and
16 criteria with respect to the functions of the Sec-
17 retary under this section including—

18 (A) priorities for the approval of applica-
19 tions;

20 (B) procedures for developing, monitoring,
21 and evaluating research efforts conducted under
22 this section; and

23 (C) such other matters as are rec-
24 ommended by the Working Group and approved
25 by the Secretary.

1 (5) CHAIRPERSON.—The Chairperson of the
2 Working Group shall be the Administrator of the
3 Agency for Health Care Policy and Research.

4 (6) QUORUM.—A majority of the members of
5 the Working Group shall constitute a quorum, but
6 a lesser number of members may hold hearings.

7 (7) MEETINGS.—The Working Group shall
8 meet at the call of the Chairperson, except that—

9 (A) it shall meet not less than 4 times each
10 year; and

11 (B) it shall meet whenever a majority of
12 the appointed members request a meeting in
13 writing.

14 (8) COMPENSATION OF MEMBERS.—Each mem-
15 ber of the Working Group shall be an officer or em-
16 ployee of the Federal Government and shall serve
17 without compensation in addition to that received for
18 their service as an officer or employee of the Federal
19 Government.

20 (e) APPLICATION.—

21 (1) IN GENERAL.—Each eligible entity which
22 desires to receive a grant under this section shall
23 submit an application to the Secretary, at such time,
24 in such manner, and accompanied by such additional

1 information as the Secretary may reasonably re-
2 quire.

3 (2) CONTENTS.—Each application submitted
4 pursuant to paragraph (1) shall—

5 (A) describe the activities for which assist-
6 ance under this section is sought;

7 (B) describe how the research effort pro-
8 posed to be conducted will reflect the medical,
9 behavioral, and social aspects of care for the el-
10 derly, lead to the development of cost-effective
11 benefits and cost-saving benefits, and impact
12 the quality of life of medicare beneficiaries;

13 (C) provide evidence that the eligible entity
14 meets the general policies established by the
15 Working Group pursuant to subsection (d)(4);

16 (D) provide assurances that the eligible en-
17 tity will take such steps as may be available to
18 it to continue the activities for which the eligi-
19 ble entity is making application after the period
20 for which assistance is sought; and

21 (E) provide such additional assurances as
22 the Secretary determines to be essential to en-
23 sure compliance with the requirements of this
24 Act.

1 (3) JOINT APPLICATION.—A consortium of eli-
2 gible entities may file a joint application under the
3 provisions of paragraph (1) of this subsection.

4 (f) APPROVAL OF APPLICATION.—The Secretary
5 shall approve applications in accordance with the general
6 policies established by the Working Group under sub-
7 section (d).

8 (g) PAYMENTS.—The Secretary shall pay to each eli-
9 gible entity having an application approved under sub-
10 section (f) the cost of the activities described in the appli-
11 cation.

12 (h) EVALUATION AND REPORT.—

13 (1) EVALUATION.—The Secretary shall conduct
14 an annual evaluation of grants made under this sec-
15 tion to determine—

16 (A) the results of the overall applied re-
17 search conducted under this Act;

18 (B) the extent to which research assisted
19 under this section has improved or expanded
20 the general research for health promotion and
21 disease prevention among the elderly and identi-
22 fied practical interventions based upon such re-
23 search;

24 (C) a list of specific recommendations
25 based upon research conducted under this sec-

1 tion which show promise as practical interven-
2 tions for health promotion and disease preven-
3 tion among the elderly;

4 (D) whether or not as a result of the ap-
5 plied research effort certain health promotion
6 and disease prevention benefits or education ef-
7 forts should be added to the medicare program,
8 including discussions of quality of life, trans-
9 lating the applied research results into a benefit
10 under the medicare program, and whether each
11 additional benefit would be a cost-effective ben-
12 efit or cost-saving benefit for each proposed ad-
13 dition;

14 (E) the utility of, potential for, and issues
15 surrounding health risk appraisals sponsored
16 under the medicare program and targeted fol-
17 lowup; and

18 (F) how best to increase utilization of ex-
19 isting and recommended health promotion and
20 disease prevention services, including an edu-
21 cation and public awareness component discus-
22 sion of financial incentives for providers of serv-
23 ices and medicare beneficiaries to improve utili-
24 zation and other administrative means of in-
25 creasing utilization.

1 (2) ANNUAL REPORT.—Not later than Decem-
2 ber 31, 2002, and each year thereafter through
3 2005, the Secretary shall submit a report to Con-
4 gress based on the annual studies made under para-
5 graph (1), which shall contain a detailed statement
6 of the findings and conclusions of the Working
7 Group together with its recommendations for such
8 legislation and administrative actions as it considers
9 appropriate.

10 (i) AUTHORIZATION OF APPROPRIATIONS.—There
11 are authorized to be appropriated \$40,000,000 for each
12 of the fiscal years 2000, 2001, 2002, and 2003 to carry
13 out the provisions of this section.

14 **SEC. 102. SENSE OF CONGRESS REGARDING THE RESPONSE**
15 **OF HCFA TO PREVENTIVE HEALTH ISSUES.**

16 It is the sense of Congress that in administering the
17 medicare program the Secretary should ensure that the
18 Administrator of the Health Care Financing Administra-
19 tion encourages the inclusion of preventive measures as
20 part of all treatments described in such program.

1 SEC. 103. SENSE OF CONGRESS REGARDING THE EFFORTS
2 OF HCFA TO STUDY HEALTH PROMOTION
3 AND DISEASE PREVENTION FOR MEDICARE
4 BENEFICIARIES.

5 It is the sense of Congress that the Secretary should
6 ensure that the Administrator of the Health Care Financ-
7 ing Administration expands the study of the most prom-
8 ising behavioral modification of risk factors associated
9 with health promotion and disease prevention for all medi-
10 care beneficiaries.

11 SEC. 104. SENSE OF CONGRESS REGARDING THE ESTAB-
12 LISHMENT OF A MEDICARE HEALTH PRO-
13 MOTION AND DISEASE PREVENTION CLEAR-
14 INGHOUSE.

15 It is the sense of Congress that the National Library
16 of Medicine should collect information regarding innova-
17 tive and successful health promotion and disease preven-
18 tion interventions from both published and unpublished
19 sources, establish a clearinghouse targeting all medicare
20 beneficiaries in a variety of settings for the consolidation
21 and coordination of all such information, and make the
22 clearinghouse available to the public and accessible
23 through the Internet.

1 **TITLE II—MEDICARE COVERAGE**
2 **OF PREVENTIVE SERVICES**

3 **SEC. 201. COUNSELING FOR CESSATION OF TOBACCO USE.**

4 (a) **COVERAGE.**—Section 1861(s)(2) of the Social Se-
5 curity Act (42 U.S.C. 1395x(s)(2)) is amended—

6 (1) in subparagraph (S), by striking “and” at
7 the end;

8 (2) in subparagraph (T), by striking the period
9 at the end and inserting “; and”; and

10 (3) by adding at the end the following:

11 “(U) counseling for cessation of tobacco use (as
12 defined in subsection (uu)) for individuals who have
13 a history of tobacco use.”.

14 (b) **SERVICES DESCRIBED.**—Section 1861 of such
15 Act (42 U.S.C. 1395x) is amended by adding at the end
16 the following:

17 “Counseling for Cessation of Tobacco Use

18 “(uu)(1) Except as provided in paragraph (2), the
19 term ‘counseling for cessation of tobacco use’ means diag-
20 nostic, therapy, and counseling services for cessation of
21 tobacco use which are furnished by or under the super-
22 vision of a physician or other health care professional who
23 is legally authorized to furnish such services under State
24 law (or the State regulatory mechanism provided by State
25 law) of the State in which the services are furnished, as

1 would otherwise be covered if furnished by a physician or
2 as an incident to a physician's professional service.

3 “(2) The term ‘counseling for cessation of tobacco
4 use’ does not include coverage for drugs or biologicals that
5 are not otherwise covered under this title.”.

6 (c) ELIMINATION OF COST SHARING.—

7 (1) ELIMINATION OF COINSURANCE.—Section
8 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) is
9 amended—

10 (A) by striking “and (S)” and inserting
11 “(S)”; and

12 (B) by striking the semicolon at the end
13 and inserting the following: “, and (T) with re-
14 spect to counseling for cessation of tobacco use
15 (as defined in section 1861(uu)), the amount
16 paid shall be 100 percent of the lesser of the
17 actual charge for the services or the amount de-
18 termined by a fee schedule established by the
19 Secretary for the purposes of this subpara-
20 graph;”.

21 (2) ELIMINATION OF DEDUCTIBLE.—The first
22 sentence of section 1833(b) of such Act (42 U.S.C.
23 1395l(b)) is amended—

24 (A) by striking “and” before “(6)”; and

1 (B) by inserting before the period the fol-
2 lowing: “, and (7) such deductible shall not
3 apply with respect to counseling for cessation of
4 tobacco use (as defined in section 1861(uu))”.

5 (d) EFFECTIVE DATE.—The amendments made by
6 this section shall apply to services furnished on or after
7 December 31, 2001.

8 **SEC. 202. SCREENING FOR HYPERTENSION.**

9 (a) COVERAGE.—Section 1861(s)(2) of the Social Se-
10 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
11 tion 201(a)) is amended—

12 (1) in subparagraph (T), by striking “and” at
13 the end;

14 (2) in subparagraph (U), by striking the period
15 at the end and inserting “; and”; and

16 (3) by adding at the end the following:

17 “(V) screening for hypertension (as defined in
18 subsection (vv)) not more frequently than once every
19 2 years for individuals with normotensive blood pres-
20 sure measurements and annually for individuals with
21 blood pressure measurements that are not
22 normotensive.”.

23 (b) SERVICES DESCRIBED.—Section 1861 of such
24 Act (42 U.S.C. 1395x) (as amended by section 201(b))
25 is amended by adding at the end the following:

1 “Screening for Hypertension

2 “(vv) The term ‘screening for hypertension’ means di-
3 agnostic services for hypertension which are furnished by
4 or under the supervision of a physician or other health
5 care professional who is legally authorized to furnish such
6 services under State law (or the State regulatory mecha-
7 nism provided by State law) of the State in which the serv-
8 ices are furnished, as would otherwise be covered if fur-
9 nished by a physician or as an incident to a physician’s
10 professional service.”.

11 (c) ELIMINATION OF COST SHARING.—

12 (1) ELIMINATION OF COINSURANCE.—Section
13 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
14 amended by section 201(c)(1)) is amended—

15 (A) by striking “and (T)” and inserting
16 “(T)”; and

17 (B) by striking the semicolon at the end
18 and inserting the following: “, and (U) with re-
19 spect to screening for hypertension (as defined
20 in section 1861(vv)), the amount paid shall be
21 100 percent of the lesser of the actual charge
22 for the services or the amount determined by a
23 fee schedule established by the Secretary for the
24 purposes of this subparagraph;”.

1 (2) **ELIMINATION OF DEDUCTIBLE.**—The first
 2 sentence of section 1833(b) of such Act (42 U.S.C.
 3 1395l(b)) (as amended by section 201(c)(2)) is
 4 amended—

5 (A) by striking “and” before “(7)”; and

6 (B) by inserting before the period the fol-
 7 lowing: “, and (8) such deductible shall not
 8 apply with respect to screening for hypertension
 9 (as defined in section 1861(vv))”.

10 (d) **EFFECTIVE DATE.**—The amendments made by
 11 this section shall apply to services furnished on or after
 12 December 31, 2001.

13 **SEC. 203. COUNSELING FOR HORMONE REPLACEMENT**
 14 **THERAPY.**

15 (a) **COVERAGE.**—Section 1861(s)(2) of the Social Se-
 16 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
 17 tion 202(a)) is amended—

18 (1) in subparagraph (U), by striking “and” at
 19 the end;

20 (2) in subparagraph (V), by striking the period
 21 at the end and inserting “; and”; and

22 (3) by adding at the end the following:

23 “(W) counseling for hormone replacement ther-
 24 apy (as defined in subsection (ww)).”.

1 (b) SERVICES DESCRIBED.—Section 1861 of such
 2 Act (42 U.S.C. 1395x) (as amended by section 202(b))
 3 is amended by adding at the end the following:

4 “Counseling for Hormone Replacement Therapy

5 “(ww)(1) Except as provided in paragraph (2), the
 6 term ‘counseling for hormone replacement therapy’ means
 7 diagnostic, therapy, and counseling services for hormone
 8 replacement which are furnished by or under the super-
 9 vision of a physician or other health care professional who
 10 is legally authorized to furnish such services under State
 11 law (or the State regulatory mechanism provided by State
 12 law) of the State in which the services are furnished, as
 13 would otherwise be covered if furnished by a physician or
 14 as an incident to a physician’s professional service.

15 “(2) The term ‘counseling for hormone replacement
 16 therapy’ does not include coverage for drugs or biologicals
 17 that are not otherwise covered under this title.”.

18 (c) ELIMINATION OF COST SHARING.—

19 (1) ELIMINATION OF COINSURANCE.—Section
 20 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
 21 amended by section 202(c)(1)) is amended—

22 (A) by striking “and (U)” and inserting
 23 “(U)”; and

24 (B) by striking the semicolon at the end
 25 and inserting the following: “, and (V) with re-

1 spect to counseling for hormone replacement
 2 therapy (as defined in section 1861(ww)), the
 3 amount paid shall be 100 percent of the lesser
 4 of the actual charge for the services or the
 5 amount determined by a fee schedule estab-
 6 lished by the Secretary for the purposes of this
 7 subparagraph;”.

8 (2) ELIMINATION OF DEDUCTIBLE.—The first
 9 sentence of section 1833(b) of such Act (42 U.S.C.
 10 1395l(b)) (as amended by section 202(c)(2)) is
 11 amended—

12 (A) by striking “and” before “(8)”; and

13 (B) by inserting before the period the fol-
 14 lowing: “, and (9) such deductible shall not
 15 apply with respect to counseling for hormone
 16 replacement therapy (as defined in section
 17 1861(ww))”.

18 (d) EFFECTIVE DATE.—The amendments made by
 19 this section shall apply to services furnished on or after
 20 December 31, 2001.

21 **SEC. 204. SCREENING FOR GLAUCOMA.**

22 (a) COVERAGE.—Section 1861(s)(2) of the Social Se-
 23 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
 24 tion 203(a)) is amended—

1 (1) in subparagraph (V), by striking “and” at
2 the end;

3 (2) in subparagraph (W), by striking the period
4 at the end and inserting “; and”; and

5 (3) by adding at the end the following:

6 “(X) screening for glaucoma (as defined in sub-
7 section (xx)) for individuals determined to be at high
8 risk for glaucoma, individuals with a family history
9 of glaucoma, and individuals with diabetes or myo-
10 pia.”.

11 (b) SERVICES DESCRIBED.—Section 1861 of such
12 Act (42 U.S.C. 1395x) (as amended by section 203(b))
13 is amended by adding at the end the following:

14 “Screening for Glaucoma

15 “(xx) The term ‘screening for glaucoma’ means a di-
16 lated eye examination with an intraocular pressure meas-
17 urement, and a direct ophthalmoscopy or a slit-lamp bio-
18 microscopic examination for the early detection of glau-
19 coma which is furnished by or under the supervision of
20 an optometrist or ophthalmologist who is legally author-
21 ized to furnish such services under State law (or the State
22 regulatory mechanism provided by State law) of the State
23 in which the services are furnished, as would otherwise
24 be covered if furnished by a physician or as an incident
25 to a physician’s professional service.”.

1 (c) ELIMINATION OF COST SHARING.—

2 (1) ELIMINATION OF COINSURANCE.—Section
3 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
4 amended by section 203(c)(1)) is amended—

5 (A) by striking “and (V)” and inserting
6 “(V)”; and

7 (B) by striking the semicolon at the end
8 and inserting the following: “, and (W) with re-
9 spect to screening for glaucoma (as defined in
10 section 1861(xx)), the amount paid shall be 100
11 percent of the lesser of the actual charge for
12 the services or amount determined by a fee
13 schedule established by the Secretary for the
14 purposes of this subparagraph;”.

15 (2) ELIMINATION OF DEDUCTIBLE.—The first
16 sentence of section 1833(b) of such Act (42 U.S.C.
17 1395l(b)) (as amended by section 203(c)(2)) is
18 amended—

19 (A) by striking “and” before “(9)”; and

20 (B) by inserting before the period the fol-
21 lowing: “, and (10) such deductible shall not
22 apply with respect to screening for glaucoma
23 (as defined in section 1861(xx))”.

1 (d) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply to services furnished on or after
 3 December 31, 2001.

4 **SEC. 205. SCREENING FOR DIMINISHED VISUAL ACUITY.**

5 (a) COVERAGE.—Section 1861(s)(2) of the Social Se-
 6 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
 7 tion 204(a)) is amended—

8 (1) in subparagraph (W), by striking “and” at
 9 the end;

10 (2) in subparagraph (X), by striking the period
 11 at the end and inserting “; and”; and

12 (3) by adding at the end the following:

13 “(Y) screening for diminished visual acuity (as
 14 defined in subsection (yy)).”.

15 (b) SERVICES DESCRIBED.—Section 1861 of such
 16 Act (42 U.S.C. 1395x) (as amended by section 204(b))
 17 is amended by adding at the end the following:

18 “Screening for Diminished Visual Acuity

19 “(yy) The term ‘screening for diminished visual acu-
 20 ity’ means diagnostic services for screening for diminished
 21 visual acuity which are furnished by or under the super-
 22 vision of an optometrist or ophthalmologist who is legally
 23 authorized to furnish such services under State law (or
 24 the State regulatory mechanism provided by State law) of
 25 the State in which the services are furnished, as would

1 otherwise be covered if furnished by a physician or as an
2 incident to a physician's professional service.”.

3 (c) ELIMINATION OF COST SHARING.—

4 (1) ELIMINATION OF COINSURANCE.—Section
5 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
6 amended by section 204(c)(1)) is amended—

7 (A) by striking “and (W)” and inserting
8 “(W)”; and

9 (B) by striking the semicolon at the end
10 and inserting the following: “, and (X) with re-
11 spect to screening for diminished visual acuity
12 (as defined in section 1861(yy)), the amount
13 paid shall be 100 percent of the lesser of the
14 actual charge for the services or the amount de-
15 termined by a fee schedule established by the
16 Secretary for the purposes of this subpara-
17 graph;”.

18 (2) ELIMINATION OF DEDUCTIBLE.—The first
19 sentence of section 1833(b) of such Act (42 U.S.C.
20 1395l(b)) (as amended by section 204(c)(2)) is
21 amended—

22 (A) by striking “and” before “(10)”; and

23 (B) by inserting before the period the fol-
24 lowing: “, and (11) such deductible shall not

1 apply with respect to screening for diminished
2 visual acuity (as defined in section 1861(yy))”.

3 (d) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to services furnished on or after
5 December 31, 2001.

6 **SEC. 206. SCREENING FOR HEARING IMPAIRMENT.**

7 (a) COVERAGE.—Section 1861(s)(2) of the Social Se-
8 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
9 tion 205(a)) is amended—

10 (1) in subparagraph (X), by striking “and” at
11 the end;

12 (2) in subparagraph (Y), by striking the period
13 at the end and inserting “; and”; and

14 (3) by adding at the end the following:

15 “(Z) screening for hearing impairment (as de-
16 fined in subsection (zz)).”.

17 (b) SERVICES DESCRIBED.—Section 1861 of such
18 Act (42 U.S.C. 1395x) (as amended by section 205(b))
19 is amended by adding at the end the following:

20 “Screening for Hearing Impairment

21 “(zz) The term ‘screening for hearing impairment’
22 means diagnostic services for hearing impairment by use
23 of periodic questions, otoscopic examination and audio
24 metric testing if such questions indicate potential hearing
25 impairment, and counseling about hearing aid devices

1 which are furnished by or under the supervision of a physi-
 2 cian or other health care professional who is legally au-
 3 thorized to furnish such services under State law (or the
 4 State regulatory mechanism provided by State law) of the
 5 State in which the services are furnished, as would other-
 6 wise be covered if furnished by a physician or as an inci-
 7 dent to a physician's professional service.”.

8 (c) ELIMINATION OF COST SHARING.—

9 (1) ELIMINATION OF COINSURANCE.—Section
 10 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
 11 amended by section 205(c)(1)) is amended—

12 (A) by striking “and (X)” and inserting
 13 “(X)”; and

14 (B) by striking the semicolon at the end
 15 and inserting the following: “, and (Y) with re-
 16 spect to screening for hearing impairment (as
 17 defined in section 1861(zz)), the amount paid
 18 shall be 100 percent of the lesser of the actual
 19 charge for the services or the amount deter-
 20 mined by a fee schedule established by the Sec-
 21 retary for the purposes of this subparagraph;”.

22 (2) ELIMINATION OF DEDUCTIBLE.—The first
 23 sentence of section 1833(b) of such Act (42 U.S.C.
 24 1395l(b)) (as amended by section 205(c)(2)) is
 25 amended—

1 (A) by striking “and” before “(11)”; and

2 (B) by inserting before the period the fol-
 3 lowing: “, and (12) such deductible shall not
 4 apply with respect to screening for hearing im-
 5 pairment (as defined in section 1861(zz))”.

6 (d) EFFECTIVE DATE.—The amendments made by
 7 this section shall apply to services furnished on or after
 8 December 31, 2001.

9 **SEC. 207. SCREENING AND COUNSELING FOR**
 10 **OSTEOPOROSIS.**

11 (a) COVERAGE.—Section 1861(s)(2) of the Social Se-
 12 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
 13 tion 206(a)) is amended—

14 (1) in subparagraph (Y), by striking “and” at
 15 the end;

16 (2) in subparagraph (Z), by striking the period
 17 at the end and inserting “; and”; and

18 (3) by adding at the end the following:

19 “(AA) screening and counseling for osteoporosis
 20 (as defined in subsection (aaa)) for—

21 “(i) women; and

22 “(ii) men with fractures.”.

23 (b) SERVICES DESCRIBED.—Section 1861 of such
 24 Act (42 U.S.C. 1395x) (as amended by section 206(b))
 25 is amended by adding at the end the following:

1 “Screening and counseling for Osteoporosis

2 “(aaa) The term ‘screening and counseling for
3 osteoporosis’ means diagnostic and counseling services for
4 osteoporosis in addition to a bone mass measurement (as
5 defined in subsection (rr)) which are furnished in accord-
6 ance with methods approved by the Food and Drug Ad-
7 ministration by or under the supervision of a physician
8 or other health care professional who is legally authorized
9 to furnish such services under State law (or the State reg-
10 ulatory mechanism provided by State law) of the State in
11 which the services are furnished, as would otherwise be
12 covered if furnished by a physician or as an incident to
13 a physician’s professional service.”.

14 (c) **ELIMINATION OF COST SHARING.**—

15 (1) **ELIMINATION OF COINSURANCE.**—Section
16 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
17 amended by section 206(c)(1)) is amended—

18 (A) by striking “and (Y)” and inserting
19 “(Y)”; and

20 (B) by striking the semicolon at the end
21 and inserting the following: “, and (Z) with re-
22 spect to screening and counseling for
23 osteoporosis (as defined in section 1861(aaa)),
24 the amount paid shall be 100 percent of the
25 lesser of the actual charge for the services or

1 the amount determined by a fee schedule estab-
 2 lished by the Secretary for the purposes of this
 3 subparagraph;”.

4 (2) **ELIMINATION OF DEDUCTIBLE.**—The first
 5 sentence of section 1833(b) of such Act (42 U.S.C.
 6 1395l(b)) (as amended by section 206(c)(2)) is
 7 amended—

8 (A) by striking “and” before “(12)”; and

9 (B) by inserting before the period the fol-
 10 lowing: “, and (13) such deductible shall not
 11 apply with respect to screening and counseling
 12 for osteoporosis (as defined in section
 13 1861(aaa))”.

14 (d) **EFFECTIVE DATE.**—The amendments made by
 15 this section shall apply to services furnished on or after
 16 December 31, 2001.

17 **SEC. 208. SCREENING FOR CHOLESTEROL.**

18 (a) **COVERAGE.**—Section 1861(s)(2) of the Social Se-
 19 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
 20 tion 207(a)) is amended—

21 (1) in subparagraph (Z), by striking “and” at
 22 the end;

23 (2) in subparagraph (AA), by striking the pe-
 24 riod at the end and inserting “; and”; and

25 (3) by adding at the end the following:

1 “(BB) screening for cholesterol (as defined in
 2 subsection (bbb)) for individuals between the ages of
 3 65 and 75 that exhibit major risk factors for coro-
 4 nary heart disease, including smoking, hypertension,
 5 and diabetes.”.

6 (b) SERVICES DESCRIBED.—Section 1861 of such
 7 Act (42 U.S.C. 1395x) (as amended by section 207(b))
 8 is amended by adding at the end the following:

9 “Screening for Cholesterol

10 “(bbb) The term ‘screening for cholesterol’ means di-
 11 agnostic services for cholesterol that are furnished by or
 12 under the supervision of a physician or other health care
 13 professional who is legally authorized to furnish such serv-
 14 ices under State law (or the State regulatory mechanism
 15 provided by State law) of the State in which the services
 16 are furnished, as would otherwise be covered if furnished
 17 by a physician or as an incident to a physician’s profes-
 18 sional service.”.

19 (c) ELIMINATION OF COST SHARING.—

20 (1) ELIMINATION OF COINSURANCE.—Section
 21 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
 22 amended by section 207(c)(1)) is amended—

23 (A) by striking “and (Z)” and inserting
 24 “(Z)”; and

(B) by striking the semicolon at the end and inserting the following: “, and (AA) with respect to screening for cholesterol (as defined in section 1861(bbb)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;”.

(2) **ELIMINATION OF DEDUCTIBLE.**—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) (as amended by section 207(c)(2)) is amended—

(A) by striking “and” before “(13)”; and

(B) by inserting before the period the following: “, and (14) such deductible shall not apply with respect to screening and counseling for osteoporosis (as defined in section 1861(bbb))”.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply to services furnished on or after December 31, 2001.

SEC. 209. ELIMINATION OF COST SHARING FOR CURRENT PREVENTIVE BENEFITS.

(a) **WAIVER OF COINSURANCE AND DEDUCTIBLES.**—

1 (1) IN GENERAL.—Section 1834 of the Social
 2 Security Act (42 U.S.C. 1395m) is amended by add-
 3 ing at the end the following:

4 “(m) WAIVER OF COINSURANCE AND DEDUCTIBLE
 5 FOR PREVENTIVE SERVICES.—

6 “(1) COINSURANCE.—

7 “(A) IN GENERAL.—Notwithstanding any
 8 other provision of this part—

9 “(i) the Secretary shall waive any co-
 10 insurance applicable to services described
 11 in subparagraph (B); and

12 “(ii) with respect to payment for such
 13 services, any reference to a percent that is
 14 less than 100 percent shall be deemed to
 15 be a reference to 100 percent.

16 “(B) SERVICES DESCRIBED.—The services
 17 described in this subparagraph are the following
 18 services:

19 “(i) Screening mammography (as de-
 20 fined in section 1861(jj)).

21 “(ii) Screening pelvic exam (as de-
 22 fined in section 1861(nn)(2)).

23 “(iii) Hepatitis B vaccine and its ad-
 24 ministration (under section
 25 1861(s)(10)(B)).

1 “(iv) Colorectal cancer screening test
2 (as defined in section 1861(pp)).

3 “(v) Bone mass measurement (as de-
4 fined in section 1861(rr)).

5 “(vi) Prostate cancer screening test
6 (as defined in section 1861(oo)).

7 “(vii) Diabetes outpatient self-man-
8 agement training services (as defined in
9 section 1861(qq)).

10 “(2) DEDUCTIBLE.—

11 “(A) IN GENERAL.—Notwithstanding any
12 other provision of this part, the deductible de-
13 scribed in section 1833(b) shall not apply with
14 respect to services described in subparagraph
15 (B).

16 “(B) SERVICES DESCRIBED.—The services
17 described in this subparagraph are the following
18 services:

19 “(i) Hepatitis B vaccine and its ad-
20 ministration (under section
21 1861(s)(10)(B)).

22 “(ii) Colorectal cancer screening test
23 (as defined in section 1861(pp)).

24 “(iii) Bone mass measurement (as de-
25 fined in section 1861(rr)).

1 “(iv) Prostate cancer screening test
2 (as defined in section 1861(oo)).

3 “(v) Diabetes outpatient self-manage-
4 ment training services (as defined in sec-
5 tion 1861(qq)).”.

6 (2) CONFORMING AMENDMENT.—Section
7 1833(a) of the Social Security Act (42 U.S.C.
8 1395l(a)) is amended by striking “section 1876”
9 and inserting “sections 1834 and 1876” in the mat-
10 ter preceding paragraph (1).

11 (b) EFFECTIVE DATE.—The amendments made by
12 this section shall apply to services furnished on or after
13 December 31, 2001.

14 **SEC. 210. NATIONAL FALLS PREVENTION EDUCATION AND**
15 **AWARENESS CAMPAIGN.**

16 The Secretary, in consultation with the Director of
17 the Centers for Disease Control and Prevention, shall con-
18 duct a national falls prevention and awareness campaign
19 to reduce fall-related injuries among medicare bene-
20 ficiaries.

21 **SEC. 211. PROGRAM INTEGRITY.**

22 The Secretary, in consultation with the Inspector
23 General of the Department of Health and Human Serv-
24 ices, shall integrate the benefits described in sections 201
25 through 208 with existing program integrity measures.

1 **TITLE III—MEDICARE HEALTH**
2 **EDUCATION AND RISK AP-**
3 **PRAISAL PROGRAM**

4 **SEC. 301. MEDICARE HEALTH EDUCATION AND RISK AP-**
5 **PRAISAL PROGRAM.**

6 (a) IN GENERAL.—Title XVIII of the Social Security
7 Act (42 U.S.C. 1395 et seq.) is amended by adding at
8 the end the following:

9 “MEDICARE HEALTH EDUCATION AND RISK APPRAISAL
10 PROGRAM

11 “SEC. 1897. (a) ESTABLISHMENT.—The Secretary,
12 in consultation with the Director of the Centers for Dis-
13 ease Control and Prevention, the Administrator of the
14 Agency for Health Care Policy and Research, and the Ad-
15 ministrator of the Health Care Financing Administration,
16 shall establish a health education and risk appraisal pro-
17 gram to inform the target individuals described in sub-
18 section (b) of the major behavioral risk factors described
19 in subsection (c) through the self-assessment described in
20 subsection (d) and shall conduct the periodic followup de-
21 scribed in subsection (e).

22 “(b) TARGET INDIVIDUALS.—The target individuals
23 described in this subsection are the following:

24 “(1) MEDICARE BENEFICIARIES.—Individuals
25 that are beneficiaries under this title.

1 “(2) INDIVIDUALS BETWEEN THE AGES OF 50
2 AND 64.—Individuals between the ages of 50 and 64.

3 “(c) MAJOR BEHAVIORAL RISK FACTORS.—The
4 major behavioral risk factors described in this subsection
5 include—

6 “(1) the lack of proper nutrition;

7 “(2) the use of alcohol;

8 “(3) the lack of regular exercise;

9 “(4) the use of tobacco;

10 “(5) depression; and

11 “(6) other risk factors identified by the Sec-
12 retary.

13 “(d) SELF-ASSESSMENT.—

14 “(1) IN GENERAL.—The self-assessment de-
15 scribed in this subsection is a form delivered by the
16 Secretary to each target individual that—

17 “(A) includes questions regarding major
18 behavioral risk factors;

19 “(B) requests that such individual answer
20 the questions and return the form to the Sec-
21 retary; and

22 “(C) is then assessed using—

23 “(i) knowledge coupling computer
24 software that assesses overall health risks

1 and then provides options for management
2 of identified risk factors;

3 “(ii) nurse hotlines; and

4 “(iii) case managers as the Secretary
5 determines appropriate.

6 “(2) INDIVIDUALS BETWEEN THE AGES OF 50
7 AND 64.—With respect to the target individuals de-
8 scribed in subsection (b)(2), the Secretary shall co-
9 ordinate the delivery of the self-assessment form
10 with the issuance of the statement described in sec-
11 tion 1143(c)(2).

12 “(e) PERIODIC FOLLOWUP.—

13 “(1) MEDICARE BENEFICIARIES.—Not less fre-
14 quently than once every 2 years, the Secretary shall
15 conduct periodic followup appraisals with respect to
16 the target individuals described in subsection (b)(1)
17 to reduce major behavioral risk factors described in
18 subsection (c)—

19 “(A) by providing such individuals with—

20 “(i) information regarding the results
21 of the self-administered risk appraisal;

22 “(ii) recommendations regarding be-
23 havior modifications based on such ap-
24 praisal; and

1 “(iii) information regarding any need
2 for further assessment or treatment; and

3 “(B) by providing the information de-
4 scribed in subparagraph (A) to the provider
5 designated by such individual to receive such in-
6 formation.

7 “(2) INDIVIDUALS BETWEEN THE AGES OF 50
8 AND 64.—The Secretary shall conduct such periodic
9 followup appraisals with respect to the target indi-
10 viduals described in subsection (b)(2) as the Sec-
11 retary determines appropriate.”.

12 **TITLE IV—DISEASE SELF-MAN-** 13 **AGEMENT DEMONSTRATION** 14 **PROJECTS**

15 **SEC. 401. DISEASE SELF-MANAGEMENT DEMONSTRATION** 16 **PROJECTS.**

17 **(a) DEMONSTRATION PROJECTS.—**

18 (1) IN GENERAL.—The Secretary, acting
19 through the Administrator of the Health Care Fi-
20 nancing Administration, shall conduct demonstration
21 projects for the purpose of promoting disease self-
22 management for conditions identified by the working
23 group established under paragraph (2) for target in-
24 dividuals (as defined in paragraph (3)).

(2) DISEASE SELF-MANAGEMENT WORKING
GROUP.—

(A) ESTABLISHMENT.—There is established within the Department of Health and Human Services a Disease Self-Management Working Group.

(B) COMPOSITION.—The Disease Self-Management Working Group established under subparagraph (A) shall be composed of 4 members as follows:

(i) The Administrator of the Health Care Financing Administration.

(ii) The Director of the Centers for Disease Control and Prevention.

(iii) The Administrator of the Agency for Health Care Policy and Research.

(iv) The Director of the Administration on Aging.

(C) GENERAL POLICIES AND CRITERIA.—The Disease Self-Management Working Group established under paragraph (1) shall establish general policies and criteria with respect to the functions of the Secretary under this section including—

1 (i) the identification of conditions for
2 which a demonstration project may be im-
3 plemented;

4 (ii) the prioritization of the conditions
5 identified under clause (i) based on poten-
6 tial of self-management of such condition
7 to be medically effective and for such self-
8 management to be a cost-effective benefit
9 or cost-saving benefit, as those terms are
10 defined in section 3 of this Act;

11 (iii) the identification of target indi-
12 viduals;

13 (iv) the development of procedures for
14 selecting areas in which a demonstration
15 project may be implemented; and

16 (v) such other matters as are rec-
17 ommended by the Disease Self-Manage-
18 ment Working Group and approved by the
19 Secretary.

20 (3) TARGET INDIVIDUAL DEFINED.—In this
21 section, the term “target individual” means an indi-
22 vidual that is at risk for or has a condition identified
23 by the working group described under paragraph (2)
24 and is eligible for benefits under the fee-for-service
25 program under parts A and B of title XVIII of the

1 Social Security Act (42 U.S.C. 1395c et seq.; 1395j
2 et seq.) or is enrolled under the Medicare+Choice
3 program under part C of title XVIII of such Act (42
4 U.S.C. 1395w-21 et seq.).

5 (b) NUMBER, PROJECT AREAS, AND DURATION.—

6 (1) NUMBER.—Not later than 2 years after the
7 date of enactment of this Act, the Secretary shall
8 implement a series of demonstration projects.

9 (2) PROJECT AREAS.—The Secretary, acting
10 through the Administrator of the Health Care Fi-
11 nancing Administration, shall implement the dem-
12 onstration projects described in paragraph (1) in
13 urban, suburban, and rural areas.

14 (3) DURATION.—The demonstration projects
15 under this section shall be conducted for a period of
16 3 years, beginning on the date on which the Sec-
17 retary implements the initial demonstration project.

18 (c) REPORTS TO CONGRESS.—

19 (1) ANNUAL REPORTS.—

20 (A) IN GENERAL.—Not later than 1 year
21 after the Secretary implements the initial dem-
22 onstration project under this section, and bian-
23 nually thereafter, the Secretary shall submit to
24 Congress a report regarding the demonstration
25 projects conducted under this section.

1 (B) CONTENTS OF REPORT.—The report
2 in subparagraph (A) shall include the following:

3 (i) A description of the demonstration
4 projects conducted under this section.

5 (ii) An evaluation of—

6 (I) whether each benefit provided
7 under the demonstration project is a
8 cost-effective benefit or a cost-saving
9 benefit;

10 (II) the level of the disease self-
11 management attained by target indi-
12 viduals under the demonstration
13 projects; and

14 (III) the satisfaction of target in-
15 dividuals under the demonstration
16 project.

17 (iii) Any other information regarding
18 the demonstration projects conducted
19 under this section that the Secretary deter-
20 mines to be appropriate.

21 (2) FINAL REPORT.—Not later than 1 year
22 after the conclusion of the demonstration projects
23 under this section, the Secretary shall submit a final
24 report to Congress on the demonstration projects
25 conducted under this section containing the rec-

ommendations of the Secretary regarding whether to conduct the demonstration projects on a permanent basis, together with such recommendations for legislation and administrative action as the Secretary considers appropriate.

(d) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) an amount not to exceed \$30,000,000 for the costs of carrying out the demonstration projects under this section, establishing the Disease Self-Management Working Group under subsection (a)(2), and submitting the reports to Congress under subsection (c).

TITLE V—STUDIES AND REPORTS ADVANCING ORIGINAL RESEARCH IN THE FIELD OF DISEASE PREVENTION AND THE ELDERLY

SEC. 501. MEDPAC BIENNIAL REPORT.

(a) IN GENERAL.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b–6(b)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (C), by striking “and” at the end;

(B) in subparagraph (D), by striking the period and inserting “; and”; and

(C) by adding at the end the following:

“(E) by not later than January 1, 2001, and biannually thereafter, submit the report to Congress described in paragraph (7).”; and

(2) by adding at the end the following:

“(7) EVALUATION OF ACTUARIAL EQUIVALENCE OF MEDICARE AND PRIVATE SECTOR BENEFIT PACKAGES.—

“(A) EVALUATION.—The Commission shall—

“(i) evaluate the benefit package offered under the medicare program under this title; and

“(ii) determine the degree to which such benefit package is actuarially equivalent to that offered by health benefit programs available in the private sector to individuals over age 65.

“(B) REPORT.—The Commission shall submit a report to Congress that shall contain—

“(i) a detailed statement of the findings and conclusions of the Commission re-

1 garding the evaluation conducted under
2 subparagraph (A);

3 “(ii) the recommendations of the
4 Commission regarding changes in the ben-
5 efit package offered under the medicare
6 program under this title that would keep
7 the program modern and competitive in re-
8 lation to health benefit programs available
9 in the private sector; and

10 “(iii) the recommendations of the
11 Commission for such legislation and ad-
12 ministrative actions as it considers appro-
13 priate.”.

14 (b) **EFFECTIVE DATE.**—The amendments made by
15 this section shall take effect on the date of enactment of
16 this Act.

17 **SEC. 502. NATIONAL INSTITUTE ON AGING STUDY AND RE-**
18 **PORT.**

19 (a) **STUDIES.**—The Director of the National Institute
20 on Aging shall conduct 1 or more studies focusing on ways
21 to—

22 (1) improve quality of life for the elderly;

23 (2) develop better ways to prevent or delay the
24 onset of age-related functional decline and disease
25 and disability among the elderly; and

1 (3) develop means of assessing the long-term
2 development of cost-effective benefits and cost-sav-
3 ings benefits for health promotion and disease pre-
4 vention among the elderly.

5 (b) REPORT.—Not later than January 1, 2005, the
6 Director of the National Institute on Aging shall submit
7 a report to the Secretary regarding each study conducted
8 under subsection (a) and containing a detailed statement
9 of research findings and conclusions that are scientifically
10 valid and are demonstrated to prevent or delay the onset
11 of chronic illness or disability among the elderly.

12 (c) TRANSMISSION TO INSTITUTE OF MEDICINE.—
13 Upon receipt of each report described in subsection (b),
14 the Secretary shall transmit such report to the Institute
15 of Medicine of the National Academy of Sciences for con-
16 sideration in its effort to conduct the comprehensive study
17 of current literature and best practices in the field of
18 health promotion and disease prevention among the medi-
19 care beneficiaries described in section 503.

20 (d) AUTHORIZATION OF APPROPRIATIONS.—

21 (1) IN GENERAL.—There are authorized to be
22 appropriated \$100,000,000 for fiscal years 2000
23 through 2005 to carry out the purposes of this sec-
24 tion.

1 (2) AVAILABILITY.—Any sums appropriated
2 under the authorization contained in this subsection
3 shall remain available, without fiscal year limitation,
4 until September 30, 2004.

5 **SEC. 503. INSTITUTE OF MEDICINE 5-YEAR MEDICARE PRE-**
6 **VENTION BENEFIT STUDY AND REPORT.**

7 (a) STUDY.—

8 (1) IN GENERAL.—The Secretary shall contract
9 with the Institute of Medicine of the National Acad-
10 emy of Sciences to conduct a comprehensive study of
11 current literature and best practices in the field of
12 health promotion and disease prevention among
13 medicare beneficiaries including the issues described
14 in paragraph (2) and to submit the report described
15 in subsection (b).

16 (2) ISSUES STUDIED.—The study required
17 under paragraph (1) shall include an assessment
18 of—

19 (A) whether each covered benefit is—

20 (i) medically effective; and

21 (ii) a cost-effective benefit or a cost-
22 saving benefit;

23 (B) utilization of covered benefits (includ-
24 ing any barriers to or incentives to increase uti-
25 lization); and

1 (C) quality of life issues associated with
2 both health promotion and disease prevention
3 benefits covered under the medicare program
4 and those that are not covered under such pro-
5 gram that would affect all medicare bene-
6 ficiaries.

7 (b) REPORT.—

8 (1) IN GENERAL.—Not later than 5 years after
9 the date of enactment of this section, and every fifth
10 year thereafter, the Institute of Medicine of the Na-
11 tional Academy of Sciences shall submit to the
12 President a report that contains a detailed state-
13 ment of the findings and conclusions of the study
14 conducted under subsection (a) and the rec-
15 ommendations for legislation described in paragraph
16 (2).

17 (2) RECOMMENDATIONS FOR LEGISLATION.—
18 The Institute of Medicine of the National Academy
19 of Sciences, in consultation with the Partnership for
20 Prevention, shall develop recommendations in legis-
21 lative form that—

22 (A) prioritize the preventive benefits under
23 the medicare program; and

1 (B) modify preventive benefits offered
2 under the medicare program based on the study
3 conducted under subsection (a).

4 (c) TRANSMISSION TO CONGRESS.—

5 (1) IN GENERAL.—On the day on which the re-
6 port described in subsection (b) is submitted to the
7 President, the President shall transmit the report
8 and recommendations in legislative form described in
9 subsection (b)(2) to Congress.

10 (2) DELIVERY.—Copies of the report and rec-
11 ommendations in legislative form required to be
12 transmitted to Congress under paragraph (1) shall
13 be delivered—

14 (A) to both Houses of Congress on the
15 same day;

16 (B) to the Clerk of the House of Rep-
17 resentatives if the House is not in session; and

18 (C) to the Secretary of the Senate if the
19 Senate is not in session.

20 **SEC. 504. FAST-TRACK CONSIDERATION OF PREVENTION**
21 **BENEFIT LEGISLATION.**

22 (a) RULES OF HOUSE OF REPRESENTATIVES AND
23 SENATE.—This section is enacted by Congress—

24 (1) as an exercise of the rulemaking power of
25 the House of Representatives and the Senate, re-

1 spectively, and is deemed a part of the rules of each
2 House of Congress, but—

3 (A) is applicable only with respect to the
4 procedure to be followed in that House of Con-
5 gress in the case of an implementing bill (as de-
6 fined in subsection (d)); and

7 (B) supersedes other rules only to the ex-
8 tent that such rules are inconsistent with this
9 section; and

10 (2) with full recognition of the constitutional
11 right of either House of Congress to change the
12 rules (so far as relating to the procedure of that
13 House of Congress) at any time, in the same man-
14 ner and to the same extent as in the case of any
15 other rule of that House of Congress.

16 (b) INTRODUCTION AND REFERRAL.—

17 (1) INTRODUCTION.—

18 (A) IN GENERAL.—Subject to paragraph
19 (2), on the day on which the President trans-
20 mits the report pursuant to section 503(c) to
21 the House of Representatives and the Senate,
22 the recommendations in legislative form trans-
23 mitted by the President with respect to such re-
24 port shall be introduced as a bill (by request)
25 in the following manner:

1 (i) HOUSE OF REPRESENTATIVES.—In
2 the House of Representatives, by the Ma-
3 jority Leader, for himself and the Minority
4 Leader, or by Members of the House of
5 Representatives designated by the Majority
6 Leader and Minority Leader.

7 (ii) SENATE.—In the Senate, by the
8 Majority Leader, for himself and the Mi-
9 nority Leader, or by Members of the Sen-
10 ate designated by the Majority Leader and
11 Minority Leader.

12 (B) SPECIAL RULE.—If either House of
13 Congress is not in session on the day on which
14 such recommendations in legislative form are
15 transmitted, the recommendations in legislative
16 form shall be introduced as a bill in that House
17 of Congress, as provided in subparagraph (A),
18 on the first day thereafter on which that House
19 of Congress is in session.

20 (2) REFERRAL.—Such bills shall be referred by
21 the presiding officers of the respective Houses to the
22 appropriate committee, or, in the case of a bill con-
23 taining provisions within the jurisdiction of 2 or
24 more committees, jointly to such committees for con-

1 sideration of those provisions within their respective
2 jurisdictions.

3 (c) CONSIDERATION.—After the recommendations in
4 legislative form have been introduced as a bill and referred
5 under subsection (b), such implementing bill shall be con-
6 sidered in the same manner as an implementing bill is con-
7 sidered under subsections (d), (e), (f), and (g) of section
8 151 of the Trade Act of 1974 (19 U.S.C. 2191).

9 (d) IMPLEMENTING BILL DEFINED.—In this section,
10 the term “implementing bill” means only the recommenda-
11 tions in legislative form of the Institute of Medicine of the
12 National Academy of Sciences described in section
13 503(b)(2), transmitted by the President to the House of
14 Representatives and the Senate under subsection 503(c),
15 and introduced and referred as provided in subsection (b)
16 as a bill of either House of Congress.

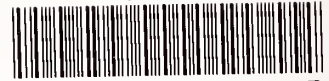
17 (e) COUNTING OF DAYS.—For purposes of this sec-
18 tion, any period of days referred to in section 151 of the
19 Trade Act of 1974 shall be computed by excluding—

20 (1) the days on which either House of Congress
21 is not in session because of an adjournment of more
22 than 3 days to a day certain or an adjournment of
23 Congress sine die; and

- 1 (2) any Saturday and Sunday, not excluded
- 2 under paragraph (1), when either House is not in
- 3 session.

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